Telemedicine Clinical Advisory Group (TCAG)
July 21, 2011
Meeting Notes

Attendees

Attended in person: Robert Bass-MIEMSS, TCAG Chair, Barney Stern, U of Maryland, Anna Aycock-MIEMSS, E. F. Magee-MIEMSS, Pat Gainer-MIEMSS, Rich Colgan-UMB, Grace Zaczek-DHMH, Neal Reynolds –STC/MEDCHI, Marc Zubrow-Christian Health Care Heath System, Jennifer Witten-American Heart & Stroke Association, Sarah Orth-Maryland Health Care Commission, Eric Stoddard–U of M CHHS, Michelle Clark-Maryland Rural Health Association
Attended via teleconference: Karen S. Rheuban MD-University of Virginia, Jo Wilson-Western Maryland Health System, Eric Aldrich-JHHS/HCGH, Salliann Alborn-Community Health Integrated Partnerships, Mimi Novello-Medstar Health, Frank Genova-Kaiser, Jennifer Fahey-U of M SOM, Tricia Handel, Maryland Board of Physicians, Stephen Michaels-St. Mary's Hospital/Medstar, Michael Franklin–Atlantic General Hospital, Nicole Stallings-DHMH, Amjad Riar, Governor's Commission on Asian Pacific American Affairs, Christina Shaklee-DHMH, Peggy Naleppa-PRMC, Frank Genova-Kaiser,

TCAG Discussion Notes
Meeting notes were approved for posting as written.

Welcome
Dr. Bass welcomed everyone and introduced Dr. Karen Reuban, Senior Associate Dean for CME and External Affairs, Medical Director for the Office of Telemedicine at the University of Virginia who attended via teleconference and agreed in lieu of a presentation to field questions from the TCAG regarding lessons learned during the legislative process regarding telemedicine. The Virginia legislation has instilled both collaboration and competition amongst a host of different providers and provides sustainability for individual programs such as stroke and mental health.

Discussion of Telemedicine Development in Virginia
Dr. Reuban stated that legislation was implemented regarding reimbursement for Telehealth in Virginia in January 2011 and advised that a proposal has been submitted to HRSA to serve as a Telehealth resource center for the mid-Atlantic to include the states of North Carolina, Virginia, Maryland, DC, Delaware, West Virginia and Kentucky.

Ms. Clark asked how Virginia formed and funded its non profit. Dr. Reuban stated that a 501C3 was formed called the Virginia Telehealth Network (VTN). Although not completely financially stable, it has annual investment by the by the Office of Minority Health and Health Policy of the Virginia Department of Health, part of their rural outreach grant, along with a tiered membership system in the VTN which includes corporations, state agencies, individuals and hospital systems. In addition VTN has been partially funded by grants. VTN has participated in the writing and support of grants. The VTN is a volunteer organization which has a part time Executive Director and has partnered with the broad band cable companies, AHA and academic medical centers to advance telemedicine legislation and is working to be a line item in the Virginia budget.

Dr. Reuban stated it is a slow process to create a 501c and that in may be more efficient to create an Office of Telemedicine under the Health Department for better access to data; either way a state will need an entity that can apply for grants and be viewed as independent.

Dr. Reuban stated that Virginia decided not to impose specific technical standards and leave it to the providers as to what is satisfactory. Dr. Bass noted that the feedback that the TCAG can give to the Telemedicine Technical Advisory Group is to be careful that the technical standards do not become a barrier since technology changes so quickly. Dr. Reuban stated that the American Telemedicine Association has practice guidelines for eleven specialties.

Ms. Witten asked if there was any consideration within the clinical and technological standards that were included in the reimbursement legislations in Virginia. Dr. Reuban said that the bill included interactive video conferencing to be covered, but left open the room for negotiations for stored forward technologies.

Ms. Orth asked how the state of Virginia assured interoperability with no standards in place.
Dr. Reuban stated they tried to select equipment that is interoperable, but it is not imposed on the providers. Dr. Reuban also stated they have a list they offer to providers of interoperable equipment that Virginia Telehealth uses. HRSA funded Telehealth Technical Resource Center which is run out of the AFCHAN, the Native American Telemedicine program; in Alaska include lists of technologies and standards. www.afhcan.org If it is compatible with those systems they will be interoperable.

Dr. Stern asked if Virginia has used telemedicine for resident / fellow supervision. Dr. Reuban said it has been utilized for resident / fellowship supervision by their faculty for Telepsychiatry but not for residents / fellows in remote locations but it is under consideration. The VTN is currently partnering on remote supervision for nurse practitioners analysis proposal through the Virginia Health Department workforce grant as a solution to workforce issues in remote areas.

When asked by Dr. Stern what how support and project setting was decided upon when setting up the 501c, Dr. Reuban stated that the Board looked at strategic imperatives and started with the Medicare / Health IT funding which was used for the Telestroke initiative and then considered what grant funding was available. Grant funding guides initiatives for Telehealth and distance learning for Virginia.

Dr. Stern asked if Virginia has accrued any data that would demonstrate the cost impact on patient care, regionally or statewide; Dr. Reuban stated that at the University of Virginia she has analyzed some financial data, but the VTN has not had time to do so since the law did not go into effect until January 2011. Mileage has been tracked through the University of Virginia program and telemedicine has saved patients 6.5 million miles of travel for access to health care; patients and Medicaid has benefited in cost savings. Dr. Reuban noted that Virginia is investigating the use of remote patient monitoring as a means to reduce the number of admission for the same diagnosis.

Dr. Reuban noted that when defining the definition for legislation, payers prefer the term Telemedicine vs. Telehealth since they believe Telehealth contains a distance learning component. Payers were ensured that it would not cost more for a telemedicine encounter. A system was worked out in Virginia in terms of reimbursement that consultants charge the professional component and consult origination site charges the technical component for the services they provide which all equal one normal specialty patient encounter.

Dr. Reynolds asked if Virginia have recommendations for telemedicine systems. Dr. Reuban said the VA health department has a video teleconferencing system and any new or build out would need to be interoperable with their system since the health departments are utilized.
Dr. Aldrich said the TCAG should not get mired down in individual devices and should focus on the capabilities that we would want and TCAG should come up with a list of needs. Dr. Bass stated the TCAG needs to define the functionality that will be needed for the care of the patient and to lend assistance to the technical group with interoperability. Dr. Stern who also sits on the Telemedicine Technical Advisory Group stated that the technical group agrees with this approach.

A discussion ensued regarding the various grants that Virginia has utilized for Telehealth and Telemedicine. The Virginia program has been supported by:

- The Department of Commerce
- The FCC
    - Two programs that have impact on telemedicine and Telehealth providers
        - Universal Services Appropriations
            - Rural Health Care support
            - Can offset monthly broadband charges
            - Has to be not for profit sites
        - Rural healthcare pilot program
            - Infrastructure costs – rural & urban
- HRSA (multiple grants)
- US Department of Agriculture
    - Telemedicine and distant learning grant program
- VA
    - The VA Innovation Initiative
- NIH

Ms. Clark asked who assisted with the completion of the grant applications. Dr. Reuban stated that the University of Virginia does the applications for the entities in their network.
Dr. Reynolds asked if Virginia would assist Maryland in knowing what grants are available. Dr. Reuban stated they would assist with as many resources as possible such but could not write a grant for another state. Clinical Trial recruitments will be important for networks.

Ms. Zaczek asked if the resource center could develop and share any boiler plate grant application language that can be applied to multiple grants and also develop lists or examples of types of data that are required in order for each state to have a portfolio to have readily accessible when grants become available. Dr. Reuban said if the HRSA grant is awarded that these could be done and additional information such as Health Department status indicators could be shared.

Ms. Zaczek asked Dr. Reuban for data regarding cost savings for telemedicine. Dr. Reuban said that data is available regarding travel avoidance and data for the mental health program regarding appointment no show rates that can be shared with Maryland. Dr. Reuban noted that the number one demand for services is mental health and Virginia has surpassed the $10{,}000^{th}$ mental health encounter.

Ms. Witten asked for clarification regarding what services the reimbursement bill covers. Dr. Reuban stated it covers face to face video conferencing, consultations and follow up care. Primarily E&M type services. The legislation does not state the CPT codes that are covered.

Dr. Zubrow asked if it covered Fairfax or Nova's TeleICU. Dr. Reuban would need to check to see if they explored this and stated that the process at the University of Virginia is that whether it is an inpatient or an outpatient it is considered an outpatient and billing the E&M codes. Legislation does not prescribe the use of E&M codes; that is just what Virginia is using; Virginia is exploring additional emergency room inpatient collaborations using the technology for making rounds in other hospitals.

Virginia has just completed the credentialing process through hospital based services. CMS has issued new rules regarding credentialing "A hospital or CAH that furnishes telemedicine services to its patients via an agreement with a "distant" hospital or telemedicine entity may now rely upon information furnished by the distant hospital (often a larger medical center) or telemedicine entity when making credentialing and privileging decisions for the physicians and practitioners at the distant site that will furnish the services."

Dr. Colgan provided copies of Dr. Baquet's Executive Summary Report on Policies Regarding Use and Reimbursement for Telemedicine Services in Maryland and Other States to the assembled group. Dr. Bass noted that the report would be posted to the website http://www.dhmh.state.md.us/mhqcc/telemedicine.html Dr. Colgan stated that in Dr. Baquet's study completed in 2006 regarding telemedicine in Maryland one of the barriers is that the federal government does not recognize as health professional shortage areas; does Virginia have the same issue? Since Virginia has military health entities as does Maryland has Virginia received any data, research or studies from the military that may be helpful to Maryland? Dr. Reuban stated that they did not get any data from the military and that the federal government does not recognize health professional shortage areas and Virginia faces the same challenges as in Maryland with Medicare. Rural areas in proximity to urban areas in adjacent states are also excluded by Medicare for telemedicine.

Dr. Stern noted that Maryland is the only states in the country that has a Medicare exemption for hospital reimbursement and wondered how that may play into Medicare coverage in Maryland. This will need legal examination.

Dr. Reuban stated that VTN was not an applicant in any of the grants; but, would VTN would try to broker to get people together. Any groups apply for grants need to adhere to the scoring the grant is based on.

HPSA designations from HRSA focus on primary care mental health dental and not on specialty care providers. Virginia's joint commission on health care which is a legislative commission that did a workforce analysis and identified specialty shortages which assisted in getting the legislation passed and to help focus where Virginia needs to be. Anyone who establishes a telemedicine program and offers specialty and sub specialty services in the designated regions and the states will assist.

HRSA grants will fund the establishment of Resource Center development. Other HRSA grants will cover Telehealth/telemedicine.

Dr. Riar asked if Virginia has tapped into the Licensure Portability Grants (LPG) – Dr. Reuban stated that Virginia has not accessed and state is not interested in practicing across state lines. Delaware and Maryland are not malpractice capped states. Dr. Zubrow stated that is why Delaware and Maryland pay the higher premiums. Delaware and Maryland do provide TeleICU across state line.

Dr. Bass thanked Dr. Reuban for her participation.

Ms. Wilson questioned how telemedicine crossing state line is different from Night Hawk Radiology. Mr. Franklin stated he was told radiology is an interpretation of an image and not a diagnosis. The liability exposure is different.

Identification and Discussion of Key Drivers
Reimbursement:

Dr. Bass stated that CareFirst has agreed to have personnel join the TCAG and do a presentation at a future meeting. CareFirst stated that they would like reimbursement to be consistent across all states. Ms. Witten stated that Senator Pugh's legislation last year that was modeled after the Virginia legislation.

Dr. Zubrow noted that Maryland looses out of many grants due to rural areas proximity to urban areas.

Ms. Witten stated that Maryland is closed out of many of the universal service grants based on telecommunications charges which are better in Maryland than most states.

Ms. Clark stated that Arkansas invested in telemedicine through their Medicaid program.

State Leadership:
A discussion ensued regarding having a State Office of Telemedicine vs. a 501c3 / private sector entity.

Mr. Franklin suggested running through a private corporation model to avoid state budget constraints and recommended Maryland eCare which is a LLC which was grant funded through the state level HSCRC and CareFirst BC/BS and could stand up more quickly. Dr. Bass said budget expediency issue could drive telemedicine toward something like a 501c3. Dr. Bass stated that there should be a telemedicine advisory entity for making recommendations to the state for legislation that could possibly be established through a 501c3. Mr. Franklin noted that CRISP is another ideal type of model to create.

- Ms. Orth stated that CRISP has many different funding streams including a 10 million dollar federal grant through MHCC with a specific scope of work.

Dr. Bass noted that this entity, state or private, could assist with support and tracking of federal grants, timelines, creating the office infrastructure for writing grants or supporting those that are writing grants. Build the knowledge and expertise.

Data collection and trending of data could also be a state or private entity.

Broadband access should be handled by a state fiber project such as the Department of Information Technology and could look toward state grants. Mr. Franklin stated that there is a private company that is focused on connectivity issues.

Dr. Zubrow noted that Maryland does not having pressing needs due to the proximity of rural areas to urban centers. Workforce issues in specialty and sub specialties are more of an issue in Maryland.

Dr. Bass asked for the group to consider whether the TCAG is going to recommend the state form a Telehealth/Telemedicine office or should the state try to seed a private entity, knowing that Maryland is challenged regarding grants. Dr. Bass stated that there would need to be a state office that would own the project for establishment and oversight.

Mr. Franklin asked Dr. Zubrow if Maryland eCare could pick up a Telestroke program. Dr. Zubrow stated that Maryland eCare has the structure to set up a Telestroke program and would just need a Stroke Neurologist to agree to cover the six weeks or more that would be needed and set up a charging system.

Mr. Franklin asked Dr. Bass to have Maryland eCare present at the next meeting.

Dr. Reynolds would prefer to have an open architecture and not have an organizations set standards and regulations; but, would prefer to see a facilitative structure to assist with the awareness and writing of grants and other resources.

Dr. Reynolds said he would speak with persons in California and inquire the current status of telemedicine in that state.

The role of the state will need to be defined. Dr. Bass noted that the state maintains quality by licensing. There should be clinical minimal standards of care. Dr. Riar suggested that the Board of Physicians would provide state oversight and quality assurance. Dr. Handel stated the Board of Physician's position is that if you are licensed in Maryland and practice in Maryland that you can practice telemedicine as well as face to face medicine. Telemedicine care complaints will be handled the same as face to face care complaints.

Mr. Franklin agreed with the idea of licensure but it needs to be coupled with regulations to allow for physicians who participate have reimbursement through insurance companies.

It was agreed upon that telemedicine should be a public/private partnership.

It was suggested to query other states as to any issues regarding oversight and quality assurance.

Proposed agenda items for the next meeting on August 4, 2011 at 10am:

- University of Maryland School of Law presentation on white paper
- CRISP – Sarah Orth to provide presentation
- Maryland eCare experience / presentation
- CareFirst presentation
- Models and best practices
- Legislative proposals
- Over arching uses of Telehealth

Copy of the Virginia Law to be posted to the web site